92-214

No.

Supreme Court, U.S.
AUG 3 1992
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1992

CURATORS, UNIVERSITY OF MISSOURI,
Petitioner,

v.

LOUIS W. SULLIVAN,
Secretary of Health and Human Services,
Respondent,

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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Kwik Kopy Printing 1992

QUESTIONS PRESENTED

I.

Can an administrative agency destroy administrative appellate review, and ultimately judicial review, of its decision by a later arbitrary recasting of its previous determination of the administrative appellate process to be used by an aggrieved party?

II.

Will the decision of the Eighth Circuit, which already conflicts with the Sixth Circuit decision of *Highland District Hospital v. Secretary of Health and Human Services*, 676 F.2d 230 (1982), create more conflicts and litigation by its explicit recognition that an aggrieved party has a choice of administrative appellate procedures instead of the determination of the appropriate appellate procedure by the Secretary of Health and Human Services as directed by Congress.

LIST OF PARTIES

In the proceeding below the Curators of the University of Missouri and Louis Sullivan, Secretary of Health and Human Services were the only parties.

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No.

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1992

THE CURATORS OF THE UNIVERSITY OF MISSOURI,

Petitioner,

v.

LOUIS W. SULLIVAN,
Secretary of Health and Human Services,
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

The Curators of the University of Missouri respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the Eighth Circuit (App. A, *infra*, A-1 to A-7) is reported at 963 F.2d 220 (1992) The opinion of the district court (App. B., *infra*, B-1 to B-21) is not reported.

JURISDICTION

The opinion and Judgment of the Court of Appeals were entered on May 4, 1992. On June 9, 1992 the Court of Appeals issued an order denying the suggestion of Petitioner for rehearing *en banc.* Despite the fact that no petition for rehearing had been filed the Eighth Circuit stated that "the Petition for rehearing is also denied" in that same order.

Petitioner seeks this Court's review pursuant to 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS INVOLVED*

28 U.S.C. §1291

42 U.S.C. §1395f(c)

42 U.S.C. §1395g

42 U.S.C. §1395h

42 U.S.C. §1395x(v)(1)(A)

42 U.S.C. §1395cc

42 U.S.C. §1395oo.

42 C.F.R. Chap. IV

42 C.F.R. §405.1835

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*The statutory and regulatory texts are set forth in Appendix D.

STATEMENT OF THE CASE

1. Proceedings Before the Provider Reimbursement Review Board

The Petitioner operates, as part of the University of Missouri System, a medical center and medical school known as the "University of Missouri Medical Center". This case involves the operations of that medical center and the Petitioner will be referred to as Medical Center throughout this Petition.

The Medical Center delivers health services to the public as a federally regulated Medicaid/Medicare provider. The Secretary's designated intermediary, Blue Cross-Blue Shield of Missouri ("Blue Cross"), disallowed Medicaid reimbursement payments to the Medical Center for certain services furnished to patients for the fiscal years ending June 30, 1979-81. Blue Cross so ruled because the Medical Center furnished those services via a PICU (Pulmonary Intensive Care Unit) sharing arrangement with a V.A. Hospital, allegedly rendering those services ineligible for reimbursement. Health care providers who are aggrieved by an intermediary's decision must pursue one of two appellate

remedies: a direct appeal to the Provider Reimbursement Review Board ("PRRB"), or pursuit of its patients directly. The intermediary designates which remedy a provider must use. Blue Cross directed the Medical Center to appeal, if at all, PRRB.

The Medical Center appealed each ruling for each year to the PRRB, and the three appeals were consolidated. At no point did Blue Cross initiate the process of required patient notification to allow the Medical Center to pursue those patients. In 1988, seven years after the appeal process began, Blue Cross moved to dismiss the appeal, alleging the PRRB's lack of jurisdiction. Blue Cross argued that the issue was one of "coverage" (over which the PRRB would not have jurisdiction) rather than "reimbursement". The PRRB agreed and dismissed the appeal.

2. Proceedings in the District Court

The Medical Center filed an action in the United States District Court for the Western District of Missouri appealing the PRRB's decision. On cross motions for summary judgment, the Honorable D. Brook Bartlett sustained the Secretary's motion, and affirmed the PRRB's lack of jurisdiction.

3. Proceedings In The Court of Appeals

The Medical Center appealed to the United States Court of Appeals for the Eighth Circuit. That court found the Medical Center had a "persuasive and equitable argument" that it had been "unfairly deprived...of an opportunity to recover its costs". The panel also wrote, however, that its understanding of two legal sources (42 U.S.C. §1395oo(g)(1) and *Highland District Hospital v. Secretary of Health and Human Services*, 676 F.2d 230 (6th Cir. 1982), required a holding against the Medical Center. The Eighth Circuit panel held (without mentioning the Secretary's failure to notify patients of the alleged "coverage" denials) that the Medical Center could have ignored the direction to

appeal to the PRRB and chosen to pursue its patients directly.

4. Basis for Federal Jurisdiction in the Court of First Instance.

This action began with the underlying agency decision rendered by the Provider Reimbursement Review Board of the Department of Health and Human Services in Baltimore, Maryland. The jurisdiction of the Provider Reimbursement Review Board was pursuant to 42 C.F.R. §405.1835. Direct review of the agency decision in the United States District Court for the Western District of Missouri was founded on 42 U.S.C. §1395oo(f). The judgment of the District Court was entered on June 24, 1991. A Notice of Appeal was timely filed pursuant to Rules 3 and 4 of the Federal Rules of Appellate Procedure on August 22, 1991. The United States Court of Appeals for the Eighth Circuit had jurisdiction of the underlying appeal pursuant to 28 U.S.C. §1291.

ARGUMENT

I.

Introduction

1. Judicial Review of Administrative Decisions

It is a touchstone of American jurisprudence that administrative decisions which affect individuals and ultimately the population at large are subject to intermediate appellate review and ultimately judicial review. Judicial review of administrative actions is presumed unless there is strong congressional intent to the contrary. *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 681 (1986). Unless certiorari is granted in this case, this presumption of review will vanish from the ambit of regulated health care costs. The Eighth Circuit's opinion explicitly encourages health care providers to ignore and second-guess administrative determinations as to which administrative appellate procedural path to follow.

This case arises from an administrative health care cost determination by the Respondent's (Secretary) intermediary, Blue Cross. Blue Cross directed the Medical Center to appeal certain Medicare cost

adjustments to the PRRB. There was absolutely no discretion or choice whatsoever available to the Medical Center as to the choice of administrative appellate forum. *Highland District Hospital v. Secretary of Health and Human Services*, 676 F.2d 230 (6th Cir. 1982). Petitioner followed these explicit orders of the intermediary. Years later, Blue Cross asserted, in direct contravention and with total disregard of its earlier decision directing the Medical Center to appeal to the PRRB that the PRRB did not have jurisdiction of the appeal in question. The intermediary moved to dismiss the Medical Center's appeal to the PRRB, which appeal it had explicitly directed the Medical Center to undertake. The PRRB granted the Motion to Dismiss.

From this simple set of facts the needless trek of this case to this Court begins. Only this Court can provide guidance to parties such as the Petitioner as well as the health care industry at large as to what review there will be of decisions of the Secretary's intermediaries. Unless this Court gives such guidance, the presumption of review will be thwarted.

There will also certainly be increased litigation since the Eighth Circuit opinion encourages providers to make their own choice of Medicare debtor as well as which administrative appellate process to pursue. The potential of a free choice of administrative appellate procedures was strongly and rightfully condemned by the Sixth Circuit in *Highland District Hospital*, 676 F.2d 220.

2. The Statutory Scheme of Appellate Review

Health care providers such as the Medical Center are entitled to reimbursement of reasonable costs for services provided to qualified beneficiaries. 42 U.S.C. §1395g. The Secretary appoints a fiscal intermediary such as Blue Cross to review claims and award reimbursement. 42 U.S.C. §1395h. The intermediary determines whether the services are covered by the Medicare Act, and if so, whether the amount charged is a reasonable cost for the service. 42 U.S.C. §1395x(v)(1)(A). If the intermediary decides the service is covered but adjusts the amount for reasons of reimbursement, it directs an appeal to the PRRB. 42 U.S.C. §1395oo. If a service is not covered by the Medicare Act, the provider must seek payment directly

from its patients but only after those patients are specifically and individually notified by the Secretary or the intermediary that there will be no benefit paid. Unless there is a qualified exception, no payments are made to federal providers of services. 42 U.S.C. §1395f(c).

A PRRB decision that it lacks jurisdiction to decide a question of law is a final agency decision, and the provider may seek judicial review. 42 U.S.C. §1395oo(f)(1); see *Good Samaritan Hospital v. Sullivan*, 952 F.2d 1017, 1020 (8th Cir. 1992).

II.

An administrative agency cannot destroy administrative appellate review, and ultimately judicial review of its decision by a later arbitrary recasting of its previous determination of the administrative appellate process to be used by an aggrieved party.

The clear intent of Congress was to provide two distinct avenues of appellate relief for health care providers, each with their own procedural and substantive due process guaranties. That same Congressional intent clearly gave the choice of the appellate remedy to be utilized **to the Secretary** and not, in any fashion, to a provider.

The Eighth Circuit's opinion offers little guidance to the Medical Center or other providers who will certainly face this same dilemma in the future. The Medical Center is told it should have disobeyed the Secretary's instructions as to where to appeal the Secretary's decision, and that the decision of the Sixth Circuit in *Highland District Hospital*, 676 F.2d at 220, rendered a year after its appeal to the PRRB, indicated "at least a distinct *possibility*" [emphasis added] of a lack of PRRB jurisdiction. 963 F.2d at 222 (A-6). Upon this

foundation the actions below were affirmed and the Medical Center was denied any review of the Secretary's decisions made in 1979, 1980 and 1981 denying it Medicare payments.

The discussion of the law and facts by the Eighth Circuit has an initial logical air, but on closer inspection the opinion's reasoning is facile and supported neither by statute nor case law. Indeed, the proposed conduct suggested by the opinion that, "[a]ppellant had the opportunity to dismiss the PRRB appeal and pursue payment directly from its patients" 963 F.2d at 222 (A-6) is simply impossible and illegal. **Any pursuit of individual patient payments requires the Secretary's intermediary to individually notify each patient. If the Appellant were to undertake this pursuit of individual patients without their express notification by the Secretary, that conduct could result in decertification as a provider under 42 U.S.C. §1395cc.** Thus, the conduct proposed by the Eighth Circuit would place the Medical Center in the same situation for which it now seeks relief from this Court; i.e. the denial of a means of recovering Medicare payments. The Medical Center

cannot take matters into its own hands and, despite the unsupported belief of the Eighth Circuit, notify its patients that there are no Medicare benefits and then pursue those patients individually. See, *Highland District Hospital*, 676 F.2d at 238-239. It is the Secretary, not the Medical Center, who must notify the patients of their appellate rights set forth in parts G and H of the Health Care Financing Regulations, 42 C.F.R. Chap. IV. These are actions and notifications that can be taken only by the Secretary. The Medical Center simply cannot dismiss its appeal to the PRRB, precisely where it was instructed to appeal, and then pursue individual patients. There must be a separate affirmative act by the Secretary in notifying the individual patients that there would be no benefit payments.

Had the Medical Center dismissed its appeal to the PRRB, as suggested by the Eighth Circuit, the Medical Center could not have pursued the individual patients since the Secretary had not notified the individual patients. The Secretary could merely decide not to make such notifications. In fact, that is precisely

what the Secretary did in 1985. (See, Letter of C. Terry to J. Rallo (Appendix E)).

Significantly absent from the Eighth Circuit opinion is any discussion of the fact that the Secretary previously made a definite decision not to notify the individual patients so that the Medical Center could undertake the alternate collection process directed by the Eighth Circuit. Instead the Secretary chose to send the Medical Center down the path of the presently litigated appeals process. This previous decision of the Secretary, which makes ineffective the Eighth Circuit's suggested dismissal by the Medical Center of its PRRB appeal, appears in a letter dated August 6, 1985, from the intermediary's audit manager, Cecil Terry, to PRRB advisor, Joseph Rallo, stating:

> While it had been the Intermediary's intent to reprocess and reject the claims for services rendered in the VAH, as noncovered services rendered to inpatients of the VAH, at the time these lists of noncovered Pulmonary ICU claims were transmitted to the Intermediary's Claims Department, temporary systems problems prevented this action. Subsequently, because of the passage of time, HCFA

> priorities and workload volume *the Intermediary has determined that it would be administratively impracticable and cost prohibitive to reprocess and formally reject these claims . . . the Intermediary does not plan to reprocess and rescind the subject claims.*

(Appendix, E-2) (emphasis added).

The Eighth Circuit has now told the Medical Center to do something that can only be done by the intermediary, and which the intermediary specifically refused to do over seven years ago! Moreover, the letter quoted above sets forth the precise reason why the Secretary instructed the Medical Center to appeal to the PRRB rather than directing pursuit of payments from the individual patients. That reason is the failure of the internal systems, and the attendant problems of the intermediary, which is solely the responsibility of the intermediary. The Eighth Circuit's teaching would essentially have the Medical Center futilely attempt a course of conduct previously specifically rejected by the intermediary. The Medical Center cannot force its own choice of appellate remedies upon the Secretary. There is absolutely no authority whatsoever which allows the

Medical Center to choose its own form of administrative appellate remedy.

As recognized by the Sixth Circuit in *Highland Hospital*, a provider such as the Medical Center may have very good reasons to prefer to look to either the federal government or its patients as its debtor of choice but it has absolutely no independent right to choose the procedure or its debtors; "it must follow the review procedures set forth in the statute and regulations". 676 F.2d at 239. This is precisely what the Medical Center did here, but is now denied an appeal based on the same decision.

The Secretary, and now the Eighth Circuit, has imposed a malignant Hobson's Choice upon the Medical Center and any other provider in circumstances in which, due to the Secretary's and intermediary's failure to use payment adjustment procedures for "coverage" issues, the provider is directed to appeal to the PRRB. The Medical Center can: (1) defy the Secretary's/Intermediary's direction and suffer decertification, 42 U.S.C. §1395cc; *Highland Hospital, supra*, or (2) obey the Secretary's/

Intermediary's direction and risk dismissal on jurisdictional grounds when or if the PRRB is swayed by "coverage" arguments. The Secretary can now have it both ways. **The Secretary may now constitutionally destroy the possibility of any appeal from an intermediary's decision. Such a unilateral destruction of appeal rights is fundamentally inconsistent with due process and the obvious intent of Congress. Yet, on the facts in this case, the Eighth Circuit's ruling sanctions that destruction and, by definition, provides intermediaries with a means for insulating their decisions from any sort of appellate review.**

The Secretary should not relegate providers to a dead-end procedure by his course of conduct. Here the Medical Center undertook the appellate rights mandated by the Secretary, and the Secretary alone. Midway through that procedure, the Secretary penalized the Appellant for following the Secretary's own directions. The Medical Center has **no** remedy for the Secretary's conduct! Such "bureaucratic ordering" and "red tape" should not strangle a provider's right to judicial review, or go unchecked by the judiciary. See *Beverly Hospital*

v. Bowen, 872 F.2d 483, 486 (D.C. Cir. 1989); and *Memorial Hospital v. Sullivan*, 779 F.Supp. 1410, 1412 (D.D.C. 1991).

III.

The decision of the Eighth Circuit, which already conflicts with the Sixth Circuit decision of *Highland District Hospital v. Secretary of Health and Human Services*, 676 F.2d 230 (1982), will create more conflicts and litigation by its explicit recognition that an aggrieved party has a choice of administrative appellate procedures instead of a determination by the Secretary of Health and Human Services of the appropriate appellate procedure as directed by Congress.

The opinion of the Eighth Circuit is the antithesis of the logical and rational holding of the Sixth Circuit in *Highland District Hospital*, 676 F.2d 230. Providers should not be allowed to choose appellate procedures or their debtors. This disruption of Congress' statutory scheme of two separate appellate paths must be considered in weighing the impact of the decision of the Eighth Circuit upon the conflicting decision of the Sixth Circuit in *Highland District Hospital, supra*.

The facts in *Highland District Hospital* are the mirror image of the facts here. There, the intermediary

determined that certain items were not "covered" costs. Blue Cross notified the various patients that payments could not be made to Highland in their behalf and, that as a result, the patients were liable to Highland for the various costs. 676 F.2d at 232-233. Despite Blue Cross' designation of the disputed items as "coverage" issues with appropriate appellate procedures available to the patients, Highland appealed on its own authority to the PRRB on the basis of reimbursement. In essence, Highland attempted to do precisely what the Eighth Circuit suggests the Medical Center should have done. The PRRB properly dismissed Highland's request for review due to the lack of jurisdiction. 676 F.2d at 233. The District Court affirmed the dismissal and Court of Appeals agreed that the PRRB lacked jurisdiction since the appellate rights for "coverage" issues were solely those of the patients. The Sixth Circuit noted:

> Highland's attempt to invoke a separate avenue of review through the PRRB to obtain payment was, in effect, an effort to substitute the federal government for the patient as the debtor. While there are certain practical differences between a creditor of the federal government and a

> creditor of an individual patient, *Mount Sinai, supra*, 517 F.2d at 335, Congress did not intend to allow both the patient debtor and the provider creditor to appeal the determination of the fiscal intermediary... *Highland's* remedy is to collect from the patient who then contests the "coverage" issue with the Secretary.

676 F.2d at 238.

It should be noted that in *Highland*, **all** of the various appellate rules and regulations involving "coverage" issues and the rights of the individual patients to appeal were followed by the intermediary. The patients received notice that they were allowed to appeal and that there would be no Medicare benefits. Highland Hospital was then no longer bound not to charge those patients. It could pursue them as individual debtors since the patients were contractually liable to Highland and the patients had the ability to pursue the available administrative and judicial avenues. 676 F.2d at 238. Based upon that rationale, the Sixth Circuit found that Highland could not appeal to the PRRB.

If *Highland* is followed, the opposite result should obtain here. Simply put, Blue Cross determined the Medical Center was a creditor of the federal government and not the individual patients. As noted by the Sixth Circuit, a provider such as the Medical Center has no independent right to cost payments, or a choice as to its debtor. It must follow the review procedures set forth in the statute and regulations after the intermediary makes its decision. That is what the Medical Center did in this case.

This logical policy enunciated by the Sixth Circuit concerning providers' inability to choose their debtors and the resulting cost savings to all parties will simply no longer apply. In the future, a provider will take the position that it has reasonable cause to decide that it can pursue a different debtor and pursuant to the Eighth Circuit's *"Curators"* decision, follow a different appellate remedy other than the one designated by the Secretary or his intermediary. This previously unavailable forum-shopping will arise from the providers' **own** position that the review designated by the Secretary is inappropriate for a given factual situation. While this scenario may

seem rather frightening, it is clearly the position enunciated in great detail by the Eighth Circuit. Judge Longstaff told the Medical Center that it should have dismissed the appeal, designated by the Secretary, and instead pursued individual patients. Instead of a uniform system of administrative determinations, administrative appellate procedures and ultimate judicial review, the decision of the Eighth Circuit will insure that there will be numerous proceedings with never-ending disagreements over what is the exact jurisdictional role of the intermediaries as well as the various administrative appellate bodies. This potential for needless non-productive litigation would be the result of this conflict between the Circuit Courts. Expensive and inefficient use of judicial resources alone is enough for this Court to grant certiorari.

The law should always attempt to be well settled. If a choice of forum is given to litigants, then that choice should be based on reason and logic. The reduction of controversies and arguments as to jurisdiction should be diminished, not fostered. The law should not lead to additional controversies, it should resolve them.

CONCLUSION

The Medical Center has not been paid for services it delivered and has been denied review of this nonpayment. This Court deals in realities. This case involves bureaucratic hamstringing that requires judicial intervention. Medical services and the costs of their delivery are extraordinarily important social issues. There is no public benefit in reaching the result of the Eighth Circuit.

The same case can easily happen again to another Medicare provider unless this Court provides teaching on the future conduct of the Secretary and Medicare providers. As Justice Stevens stated in *Bowen v. Michigan Academy Family Physicians*, 476 U.S. 681 (1986):

> We ordinarily presume that Congress intends the executive to obey its statutory commands and, accordingly, that it expects the courts to grant relief when an executive agency violates such a command. That presumption has not been surmounted here.

476 U.S. at 681, 106 S.Ct at 2141.

The Eighth Circuit's rationale was based upon what the Medical Center might have done or could have done. It did not consider the actual actions and instructions of the Secretary, and that all the Medical Center could do was to react to those actions and instructions. A case should be decided upon what has been done, not what might have been. The injustices begun so many years ago by the action of the Secretary will be perpetuated unless this Court grants review.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

No. 91-2939WM

CURATORS, UNIVERSITY OF MISSOURI, Appellant,	*	
	*	Appeal from the United States
vs.	*	District Court for the
	*	Western District of Missouri
LOUIS SULLIVAN, Secretary of the Department of Health and Human Services, Appellee.	*	

Submitted: March 12, 1992
Filed: May 4, 1992

Before Wollman and Magill, Circuit Judges, LONGSTAFF*, District Judge-Iowa

The Curators, University of Missouri, appeal from a final order entered by the District Court[1] for the Western District of Missouri which granted the Secretary's motion for summary judgment. For the reasons discussed below, we affirm the judgment of the district court.

I. BACKGROUND

The University of Missouri operates the University of Missouri Medical Center (UMMC) in Columbia, Missouri. In 1979, 1980, and 1981, UMMC had a sharing arrangement for pulmonary intensive care unit (PICU) services with the Veteran's Administration Hospital. The VA Hospital is located across the street form the UMMC and connected by a tunnel. At the end of fiscal years 1979, 1980, and 1981, UMMC filed its cost reports with the fiscal intermediary for the Department of Health and Human Services who was at that time Blue Cross/Blue Shield of Missouri (Blue Cross). The intermediary adjusted the submitted costs denying all PICU payments because the services were performed by a federal provider. The intermediary advised UMMC it

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*The Honorable RONALD E. LONGSTAFF, United States District Judge for the Southern District of Iowa, sitting by designation.

[1]The Honorable D. Brook Bartlett, United States District Judge for the Western District of Missouri.

could appeal its decision to the Provider Reimbursement Review Board (PRRB).

UMMC did appeal to the PRRB. In 1988, the intermediary filed a motion to dismiss asserting the Board lacked jurisdiction because the denial of costs was based on lack of coverage rather than reimbursement. The Board granted the motion, and UMMC filed this appeal in federal district court.

II. DISCUSSION

Under the Medicare Act, 42 U.S.C. §1395 et seq., providers such as UMMC are entitled to reimbursement of reasonable costs for services provided to qualified beneficiaries. 42 U.S.C. §1395g. Generally, a fiscal intermediary is appointed to act as the Secretary's agent for reviewing claims and awarding reimbursement. 42 U.S.C.§1395h. The intermediary determines whether the services are covered by the Medicare Act, and if so, whether the amount charged is a reasonable cost for the service. 42 U.S.C. §1395x(v)(1)(A). If the service is covered but adjusted for reasons of reimbursement, the provider may appeal to the PRRB. 42 U.S.C. §1395oo. If a service is not covered by the Medicare Act, the provider must seek payment directly from its patients. Unless there is a qualified exception, no payments are made to federal providers of services. 42 U.S.C. §1395(c). A PRRB decision that it lacks jurisdiction to decide a question of law is considered a final agency decision, and the provider may seek judicial review. 42 U.S.C. §1395oo(f)(1); see *Good Samaritan Hospital v.*

Sullivan, 952 F.2d 1017, 1020 (8th Cir. 1992).

The Sixth Circuit in *Highland District Hospital v. Secretary of Health and Human Services*, 676 F.2d 230 (6th Cir. 1982), has already considered the basic jurisdictional issue presented here. In *Highland*, costs of care provided by a skilled nursing facility located within the hospital were denied by the intermediary because such services were not covered under the Medicare Act. The Highland Hospital appealed to the PRRB, but the Board ruled it did not have jurisdiction because this was a coverage issue. The district court concluded that the PRRB correctly determined a question of coverage was involved and the Board was without jurisdiction. *Id.* at 234. The Sixth Circuit Court of Appeals affirmed holding that the PRRB did not have jurisdiction to hear claims denied based on coverage according to 42 U.S.C. § 1395oo. *Id.* at 234-35. Without repeating its analysis here, we adopt the conclusions of that court. Claims based on coverage are not proper issues before the PRRB.

Appellant argues *Highland* is distinguishable from this case. In *Highland*, the intermediary did not advise the hospital to appeal to the PRRB, and the provider had unambiguous notice the payment was denied based on lack of coverage. In the present case, the denial of costs was based on coverage, but appellant was told to appeal to the PRRB. Appellant argues *Highland* restricts the Secretary to the statutory appellate course chosen by its intermediary; and because the intermediary's notice erroneously stated that appeal was

to the PRRB the Secretary should be precluded from now denying jurisdiction. Any other result, appellant asserts, would be unequitable.

We disagree. PRRB review is expressly limited as follows:

> The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y [Exclusions from coverage and medicare as secondary payer] of this title *shall not be reviewed by the Board*, or by any court pursuant to an action brought under subsection (f) [Federal Court judicial review] of this section.

42 U.S.C. §1393oo(g)(1)(emphasis added). It is clear from the analysis in *Highland* and our own reading of §1395oo that the PRRB has no discretion to hear coverage claims. The intermediary's direction to appeal cannot nullify the statute nor vest the PRRB with jurisdiction.

Such a result is not manifestly unfair for several reasons. First, the intermediary's notice clearly stated the basis for denial was because the services were performed by a federal provider. This provided appellant with notice that the denial was an issue of coverage rather than reimbursement. Further, the joint appendix contains correspondence from the PRRB in

1980 which specifically states services provided by the Veterans Administration Hospital to patients of UMMC under the sharing arrangement have previously been denied as noncovered services. Joint Appendix Volume IV at 506. Finally, appellant should have again realized there was at least a distinct possibility jurisdiction would be denied by the PRRB when the *Highland* opinion was announced in 1982.

All of the above factors should have made appellant aware of the likelihood the PRRB would dismiss the appeal for lack of jurisdiction. Appellant had the opportunity to dismiss the PRRB appeal and pursue payment directly from its patients. After more than ten years, collection from any of these patients is unlikely. Appellant chose to accept that risk, however. We will not force the PRRB to accept jurisdiction over coverage issues simply because appellant is able to articulate a persuasive and equitable argument that the intermediary's appeal notice coupled with the lengthy appeal process unfairly deprived it of an opportunity to recover its costs for these services.

Accordingly, we affirm.

A true copy.

Attest:

Clerk U.S. District Court of Appeals, Eighth Circuit

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 91-2939WMJC

The Curators of the University of Missouri, doing business as University of Missouri Medical Center, Appellant, vs. Louis W. Sullivan, M.D., Secretary of the United States Department of Health and Human Services, Appellee.	* * * * * * * * * * * * * * * * * * * *	Order Denying Petition for Rehearing and Suggestion for Rehearing En Banc

The suggestion for rehearing en banc is denied.

The petition for rehearing is also denied.

June 9, 1992

Order Entered at the Direction of the Court:

Clerk, U.S. Court of Appeals, Eighth Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR
THE WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

THE CURATORS OF THE UNIVERSITY OF MISSOURI d/b/a THE UNIVERSITY OF MISSOURI MEDICAL CENTER,	)	
Plaintiff,	)	
v.	)	No. 89-4415-CV-C-9
LOUIS W. SULLIVAN, M.D. Secretary of the United States Department of Health and Human Services,	)	
Defendant.	)	

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

The University of Missouri Medical Center (Medical Center) seeks judicial review of a decision of the Provider Reimbursement Review Board (PRRB) under Medicare. Specifically, the Board decided that it lacked subject matter jurisdiction to review a determination of Blue Cross-Blue Shield of Missouri (Blue Cross) disallowing reimbursement for services furnished by the Veteran's Administration Hospital to certain Medical Center pulmonary intensive care unit patients. The PRRB decided that it lacked jurisdiction because Blue Cross' decision resolved a "coverage" issue.

The parties have filed cross-Motions for Summary Judgment.

I. Standard for Summary Judgment

Rule 56(c), Federal Rules of Civil Procedure, provides that summary judgment shall be rendered if the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." In ruling on a motion for summary judgment, it is the court's obligations to view the facts in the light most favorable to the adverse party and to allow the adverse party the benefit of all reasonable inferences to be drawn from the evidence. *Adickes v. S. H. Kress & Co.*, 398 U.S. 144, 157, 90 S. Ct. 1598, 1608

(1970); *Inland Oil and Transport Co. v. United States*, 600 F.2d 725, 727-28 (8th Cir.), *cert. denied,* 444 U.S. 991, 100 S. Ct. 522 (1979).

If there is no genuine issue about any material fact, summary judgment is proper because it avoids needless and costly litigation and promotes judicial efficiency. *Roberts v. Browning*, 610 F.2d 528, 531 (8th Cir. 1979); *United States v. Porter*, 581 F.2d 698, 703 (8th Cir. 1978). The summary judgment procedure is not a "disfavored procedural shortcut." Rather, it is "an integral part of the Federal Rules as a whole." *Celotex Corp. v. Catrett*, 106 S. Ct. 2548, 2555 (1986); *see also City of Mt. Pleasant v. Associated Electric Cooperative, Inc.*, 838 F.2d 268, 273 (8th Cir. 1988). Summary judgment is appropriate against a party who fails to make a showing sufficient to establish that there is a genuine issue for trial about an element essential to that party's case, and on which that party will bear the burden of proof at trial. *Celotex*, 106 S. Ct. at 2553.

The moving party bears the initial burden of demonstrating by reference to portions of pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, the *absence* of genuine issues of material fact. However, the moving party *is not required* to support its motion with affidavits or other similar materials *negating* the opponent's claim. *Id.* (emphasis added).

The nonmoving party is then required to go beyond the pleadings and by affidavits, depositions, answers to

interrogatories and admissions on file, designate specific facts showing that there is a genuine issue for trial. *Id.* A party opposing a properly supported motion for summary judgment cannot simply rest on allegations and denials in his pleading to get to a jury without any significant probative evidence tending to support the complaint. *Anderson v. Liberty Lobby, Inc.*, 106 S. Ct. 2505, 2510 (1986).

A genuine issue of material fact exists 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* The evidence favoring the nonmoving party must be more than "merely colorable." *Id.* at 2511. When the moving party has carried its burden under Rule 56(c), its opponent must do more than simply show there is some metaphysical doubt to the material facts. *Matsushita Elec. Indus. Co. v. Zenith Radio*, 106 S. Ct. 1348, 1356 (1986) (footnote omitted).

The inquiry to be made mirrors the standard for a directed verdict: whether the evidence presented by the party with the onus of proof is sufficient that a jury could properly proceed to return a verdict for that party. *Anderson v. Liberty Lobby* at 2511. Essentially, the question in ruling on a motion for summary judgment and on a motion for directed verdict is whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law. *Id.* at 2512.

II. Background Regarding Medicare Program

The Medical Center is a "provider" under the Medicare Act. Institutions known as "providers" are reimbursed for the "reasonable costs" of the services they provide to qualified Medicare beneficiaries. 42 U.S.C. §1395x(v)(1)(A). Although the Secretary directly may reimburse a provider, usually a "fiscal intermediary" is appointed to act as the Secretary's agent for the purpose of reviewing claims and awarding reimbursement. 42 U.S.C. §1395h. A fiscal intermediary most often is a private insurance company. In this case, it is Blue Cross.

An intermediary makes an initial determination regarding two separate issues: 1) whether the services provided are covered by provisions of the Medicare Act; 2) whether the amount paid for the services is a "reasonable cost." Each issue is resolved under distinct procedures. Beneficiaries may directly challenge coverage determinations; a provider may do so only under certain circumstances. Only a provider may challenge an intermediary's determination as to whether or not the amount paid for services is reasonable. The Medicare Act provides for administrative and judicial review of both coverage and cost determination issues.

The PRRB is an administrative entity created by the Medicare Act to review cost determination issues. At the end of its fiscal year, a provider submits to the intermediary a cost report upon which reimbursement is based. If the provider disagrees with the amount of the intermediary's reimbursement award, it may appeal to

the PRRB. The PRRB may not review coverage issues. *Highland District Hospital v. Secretary of Health and Human Services*, 676 F.2d 230, 236 (6th Cir. 1982).

III. Plaintiff's Contentions

> Plaintiff argues that [d]ismissal by the Provider Reimbursement Review Board was erroneous and improper in that the procedures followed by the Blue Cross, agent of Defendant, were procedures provided under law for a denial of reimbursement. Plaintiff filed its appeal with the Defendant based upon the sets off on the Cost Reports by reason of reimbursement. The failure of grounds for the action of Blue Cross, therefore, did not result in a lack of jurisdiction, but rather a lack of grounds for denial of reimbursement.

Complaint at ¶10. Plaintiff asserts that it is entitled to reimbursement of $177,747, the amount the intermediary set off against its cost reports for fiscal years ending June 30, 1979, June 30, 1980, and June 30, 1981. *Id.*, 11.

Plaintiff argues that this case does not involve coverage issues because the intermediary made an initial determination that services to pulmonary intensive care unit patients were covered and that defendant is bound by this initial determination.

> In this case, the Intermediary has never denied the patient claims submitted on behalf or by

> the pulmonary intensive care unit patients. In fact, the Intermediary has admitted that it declined to go back and deny these claims based on coverage . . . . Under §405.708, the Intermediary's initial determination that these were covered services (by failure to deny the claims), was final and binding on all parties, *including* the Intermediary. . . . [S]ince Defendant long ago failed to preserve coverage questions, by the Intermediary's failure to deny the claims, Plaintiff is entitled to summary judgment as a matter of law.

Plaintiff's Opposition to Defendant's Motion for Summary Judgment at 3-4, 7.

Plaintiff also argues that the Secretary is bound by a prior determination of the PRRB involving the same parties and the same services that are at issue in this case.

> Finally, Defendant argues that even if this Court reached the issue of coverage of the pulmonary intensive care unit services, the coverage issues must be determined in Defendant's favor. Again, Plaintiff is not requesting a determination by this Court as to coverage of pulmonary intensive care unit services provided by Plaintiff at the Veteran's Administration Hospital. This question has been previously determined by the PRRB in Plaintiff's favor in *University of Missouri*

Medical Center v. Blue Cross Association/Blue Cross Hospital Service, Inc. of Missouri, PRRB hearing decision No. 79-082, November 28, 1979.

Id. at 6-7.

IV. Defendant's Contentions

Defendant argues that

> the administrative record filed herein establishes that there exists no factual or legal basis for reversing the decision of the Provider Reimbursement Review Board that the Board lacks subject matter jurisdiction to consider plaintiff's claim. Further, summary judgment is warranted because this court is prohibited from exercising jurisdiction over the administrative dispute between the parties, in accordance with the statutory language of 42 U.S.C. §1395oo(g)(1).

Defendant's Motion for Summary Judgement at 1.

V. Undisputed Facts

In 1973, the United States opened a Veteran's Administration Hospital (V. A. Hospital) immediately across the street from the Medical Center. The Medical Center and the V. A. Hospital agreed to exchange certain services. Administrative record, Vol. III at 1049-

99. The Medical Center agreed to perform various services for the V.. A. Hospital, including coronary intensive care, radiation therapy, radioisotope procedures, certain laboratory determinations and other Miscellaneous services. The V. A. Hospital agreed to perform certain services for the Medical Center, including pulmonary intensive care, cardiac catherization, pulmonary functioning testing, various laboratory determinations and other miscellaneous services. Each hospital was to charge the other at its billed charge rates for services performed. *Id.*

Blue Cross adjusted the Medical Center's Medicare cost reports for fiscal years ending June 30, 1979, June 30, 1980, and June 30, 1981. Blue Cross disallowed all Medicare reimbursement statistics applicable to the pulmonary intensive care unit cost center in the V. A. Hospital: "This unit does not qualify as a provider cost center, as it is physically located in the Veteran's Administration Hospital, Reference HIM-15-1, Sections 2202.1 and 2202.2" *Id.* at 1191, 1201, 1327.

After Blue Cross denied reimbursement to the Medical Center for the pulmonary intensive care unit services performed at the V. A. Hospital, it notified the Medical Center that: "If you disagree with adjustments aggregating $10,000 or more in program reimbursement, *your appeal is to the Provider Reimbursement Review Board. . . ." Id.* at 1189, 1223, 1368 (emphasis added). The Medical Center appealed each of the adjustments to the PRRB noting that the adjustments "relate to the *coverage* of a pulmonary I.C.U. unit located in a

Veteran's Administration Hospital" (emphasis added). *Id.*

Blue Cross advised the PRRB in a position report that Blue Cross based its adjustments denying coverage on 42 U.S.C. § 1395y(a) (3) and 42 U.S.C. § 1395f(c). *Id.* at 1036, 1278. In a letter dated August 11, 1981, Blue Cross advised the PRRB that coverage and the jurisdiction of the PRRB were fundamental issues in dispute.

> The Provider and the Intermediary disagree on whether the Board properly has jurisdiction in this case. The Provider believes that this case involves questions of application of 'reimbursement' law and regulations and is properly placed with the Board. On the other hand, the Intermediary believes that [because] this case essentially involves questions of 'claims and coverage' matters, the Board should not retain jurisdiction over it. The Provider and the Intermediary will present their views on this matter in their respective position papers.

Id. at 1319.

On August 3, 1989, the PRRB decided that it lacked jurisdiction to review plaintiff's appeal concerning Medicare reimbursement for its fiscal years ending June 30, 1979, June 30, 1980, and June 30, 1981.

> The Board, after considering the facts, the parties' contentions, the evidence presented, the testimony provided at the pre-hearing conference, and the post-hearing briefs, finds and concludes that there is no subject matter jurisdiction in this case due to the Administrator's Rulings HCFAR 83-1, dated December 2, 1982. which states: 'The PRRB lacks jurisdiction to review determinations based on coverage questions.'

Complaint at ¶5, Exhibit A.

VI. The PRRB Correctly Decided That It Lacked Jurisdiction to Review the Intermediary's Reimbursement Denial

This court has jurisdiction to review whether the PRRB properly determined that it did not have jurisdiction to review the intermediary's cost determination. "[A] decision by the PRRB refusing to exercise jurisdiction is, for the purpose of 42 U.S.C. §1395oo(f)(1), a final decision sufficient to permit judicial review." *Athens Community Hospital v. Schweiker*, 686 F.2d 989, 994 (D.C. Cir. 1982).

The jurisdiction of the PRRB is established in 42 U.S.C. §1395oo(a). This provision provides in part that a provider may obtain a hearing with the PRRB if it "is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to §1395h of this title as to the amount of total program

reimbursement due the provider for the items and services; furnished to individuals *for which payment may be made under this subchapter for the period covered by such report. . . .*" 42 U.S.C. §1395oo(a)(1)(A)(i) (emphasis added).

In construing this language, the Sixth Circuit Court of Appeals stated:

> It appears what was contemplated by this language was a review board designed to determine disputes between a provider and its fiscal intermediary over what was a reasonable cost for an admittedly covered service rendered to a Medicare beneficiary. A requirement for PRRB review under this section is a dispute concerning an item or service 'for which payment may be made,' contemplating no dispute over whether or not the item or service is 'covered' under sections 1395d and 1395y.

Highland District Hospital v. Secretary of Health and Human Services, 676 F.2d at 236.

The Sixth Circuit Court of Appeals also concluded that the composition of the PRRB indicates it was not designed to review coverage issues.

> Moreover, the structure of the PRRB as mandated by §1395oo(h) and 42 C.F.R. §405.1845 indicates it is not designed to review

> [coverage issues]. The PRRB consists of five members appointed by the Secretary. Two members of the PRRB must be representative of Provider; one member must be a certified public accountant; all must be knowledgeable in the field of cost reimbursement. The PRRB's expertise, as evidenced by its membership and the skill required of its members, is designed to determine and review issues of reasonable cost. Issues of cost are by no means simple problems . . . but they are a different species than issues of coverage.

Id.

The Medical Center agrees that the PRRB lacks jurisdiction to consider coverage issues but argues that reimbursement, not coverage, issues are involved in this case.

Coverage determination issues

> are defined by §§1395d and §§1395y. Section 1395d defines the benefits covered by Medicare: In-patient hospital services, post-hospital extended care services and post-hospital home health services with annual day or visit limits for each, §1395d(a)(1)-(3).
>
> Section 1395y defines exclusions in the general definition of scope of benefits in §1395d.

Mt. Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F.2d 329, 335 (5th Cir. 1975), *modified by* 517 F.2d 329 (5th Cir. 1975) (per curiam), *cert. denied*, 96 S. Ct. 1665 (1976).

Blue Cross denied coverage pursuant to 42 U.S.C. §1395y(a)(3) and 42 U.S.C. §1395 (f)(c) which prohibit payment for expenses incurred or services rendered by a federal entity.

Title 42 U.S.C. §1395y(a)(3) provides:

> Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services--which are paid for directly or indirectly by a governmental entity (other than under this chapter and other than under a health benefits or insurance plan established for employees of such an entity), except in the case of rural health clinic services, as defined in §1395x-(aa)(1) of this title, and in such other cases as the Secretary may specify. . . .

Title 42 U.S.C. §1395f(c) provides:

> Subject to §1395qq of this title, no payment may be made under this part (except under subsection (d) or subsection (h) of this section) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency;

> and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

The undisputed facts show that coverage issues are involved in this case. In each audited adjustment prepared by Blue Cross denying reimbursement to plaintiff, Blue Cross set forth its rationale that the pulmonary intensive care unit did not qualify as a provider cost center because it physically was located in the V.A. Hospital. Administrative Record, Vol. III at 1191, 1201, 1327. Further, Blue Cross advised the PRRB that it based its adjustments on 42 U.S.C. §1395(f)(c) and 42 U.S.C. §1395(y)(a)(3). Administrative record, Vol. III, 1036, 1278.

Title 42 U.S.C. §1395oo(g)(1) provides:

> The findings of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in §1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

This limitation on PRRB review is reiterated in the administrative regulations.

> The determination of a fiscal intermediary that no payment may be made under TITLE XVIII of the Act for any expenses incurred for items and services are excluded from coverage pursuant to Section 1862 of the Act, 42 U.S.C. 1395y (see Subpart C of this part), may not be reviewed by the Board. (Such determination shall be reviewed only in accordance with the applicable provisions of Subpart G or H of this part.)

42 C.F.R. §405.1873(b)(1).

Thus, the limitation on the review of coverage issues established in §1395oo(a) is further restricted by the express language of §1395oo(g) prohibiting review by the PRRB of a decision to deny payment based on §1395y and the administrative regulations. Accordingly, as a matter of law, the PRRB properly determined that it did not have jurisdiction to review the intermediary's cost determinations.

This conclusion was apparently shared by the Medical Center when it appealed to the PRRB stating that the adjustments "relate to the coverage of a pulmonary I.C.U. unit located in the Veteran's Administration Hospital."

Plaintiff advances various arguments as to why the PRRB had subject matter jurisdiction.

Plaintiff argues that because the intermediary denied "reimbursement," this case involves reimbursement, not coverage issues. In all situations where the intermediary determines that reimbursement erroneously was made for non-covered services, subsequent adjustments to the amount of reimbursement must follow. Therefore, denial of reimbursement does not at the same time mean that only "reimbursement" issues are involved. Any cost adjustment based on lack of "coverage" necessarily also will have some effect on "reimbursement."

Plaintiff refers to various regulations which state that the initial determination of the intermediary is final and binding on an individual or a provider unless certain steps are taken. See 42 C.F.R. §§405.708, 405.806. Plaintiff incorrectly states that an initial determination is equally final and binding on both the intermediary and the Secretary. In *Mt. Sinai Hospital of Greater Miami, Inc.*, 517 F.2d at 345, the Fifth Circuit Court of Appeals stated that "the government's common law right to recoup is available to [HHS] in its implementation of the Medicare hospital insurance program to recover from providers funds paid for [noncovered] services."

Plaintiff argues that defendant is estopped from asserting that the intermediary's decision involved coverage issues. The intermediary initially determined that the claims of pulmonary intensive care unit patients were covered. At first, the intermediary also incorrectly notified the Medical Center that its avenue of appeal was with the PRRB. Furthermore, the PRRB once

before assumed jurisdiction on an appeal by the Medical Center regarding the intermediary's denial of reimbursement for pulmonary services provided at the V. A. Hospital.

Even if plaintiff detrimentally relied on previous action by the intermediary and the PRRB, subject matter jurisdiction may not be waived. Rule 12(h), Federal Rules of Civil Procedure; *see also Athens Community Hospital, Inc. v. Schweiker*, 686 F.2d at 992. A prior erroneous decision of the intermediary or the PRRB cannot confer subject matter jurisdiction where it does not exist.

VII. Conclusion

No genuine issue of material fact remains regarding the PRRB's proper determination that it lacks jurisdiction to review the intermediary's determination that services provided to pulmonary intensive care unit patients at the V.A. Hospital involved coverage issues.

Accordingly, it is hereby ORDERED that:

1) defendant's Motion for Summary Judgment is granted; and

2) plaintiff's Motion for Summary Judgment is denied.

D. BROOK BARTLETT
UNITED STATES
DISTRICT JUDGE

Kansas City, Missouri
June 24, 1991.

APPENDIX C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 Security Boulevard
Baltimore, Maryland 21207

REFER TO:
JBR: 83-409

Location: Professional Bldg.
Room 104

G. William Weier, Esquire
Weier, Hockensmith & Sherby
P.O. Box 31158
St. Louis, MO 63131

RE: University of Missouri Medical Center, Columbia, MO, Provider No. 2678-0141, Case No. 83-409, FYEs - June 30, 1980 and 1981

The Provider Reimbursement Review Board (Board) has reviewed all of the parties' submissions and the pre-hearing conference proceedings concerning the Intermediary's Motion to Dismiss this case for lack of subject matter jurisdiction because the disputed issue pertains to "coverage." In this case the Intermediary disallowed payment for services to patients who had been transferred to a Veterans Administration hospital (which actually performed the services).

The Board, after considering the facts, the parties' contentions, the evidence presented, the testimony provided at the pre-hearing conference, and the post-

hearing briefs, finds and concludes that there is no subject matter jurisdiction in this case due to the Administrator's Rulings HCFAR 83-1, dated December 2, 1982, which states:

> "The PRRB lacks jurisdiction to review determinations based on coverage questions."

Under the provisions of 42 CFR 405.1867, the Board is bound by the provisions of title XVIII and regulations issued thereunder, as well as HCFA Rulings.

Accordingly, the Intermediary's Motion to dismiss is granted, and the case is hereby dismissed.

This determination is subject to the provisions of 42 CFR 405.1875 and 1877 (section 1878(f) of the Social Security Act, as amended).

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza

FOR THE BOARD:

Elise D. Smith
Chairman

Enclosures
Section 1878(f)(1) of the Social Security Act, as amended
42 CFR 405-18785
42 CFR 405.1877

cc: M. Harty, BCBSA
M. F. Berkey, BCBSA

JBR/cj

APPENDIX D

STATUTES

28 U.S.C. §1291

Final Decisions of District Courts

The Courts of appeals (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction of appeals from all final decisions of the district courts of the United States, the United States District Court of the District of the Canal Zone, the District Court of Guam, and the District Court of the Virgin Islands, except where a direct review may be had in the Supreme Court. The jurisdiction of the United States Court of Appeals for the Federal Circuit shall be limited to the jurisdiction described in sections 1292(c) and (d) and 1295 of this title.

42 U.S.C. §1395f
Conditions of and limitations on payment for services

(a) Requirement of requests and certificates

Except as provided in subsections (d) and (g) of this section and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if --

(1) written request, signed by such individual, except in cases in which the Secretary finds it

impractical for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that --

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an

individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraph (6) and (9) of section 1395x(e) of this title) prior to transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and

services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

(D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services;

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient

diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no late than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1395cc(d) of this title (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility);

(6) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1395x(k)(4) of this title, including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding;

(7) in the case of hospice care provided an individual --

(A)(i) in the first 90-day period --

(I) the individual's attending physician (as defined in section 1395x(dd)(3)(B) of this title), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program providing (or arranging for) the

care, each certify in writing, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated), that the individual is terminally ill (ad defined in section 1395x(dd)(3)(A) of this title),

(ii) in a subsequent 90- or 30- day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill, and

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

(B) a written plan for providing hospice care with respect to such individual has been established (before such care is provided by, or under arrangements made by, that hospice program) and is periodically reviewed by the individual's attending physician and by the medical director (and the interdisciplinary group described in section 1395x(dd)(2)(B) of this title) of the hospice program; and

(C) such care is being or was provided pursuant to such plan of care; and

(8) in the case of inpatient rural primary care hospital services, a physician certifies that such services were required to be immediately furnished on a temporary, inpatient basis.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence,

service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

(b) Amount paid to provider of services

The amount paid to any provider of services (other than a hospice program providing hospice care, other than a rural primary care hospital providing inpatient rural primary care hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e and 1395ww of this title, be-

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services;

(2) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this paragraph), free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services; or

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, if the rate of increase in such

hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then the Secretary may provide for continuation of reimbursement to such hospitals under such system until the Secretary determines that--

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the aggregate rate of increase from January 1, 1981, to the most recent date for which annual data are available in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part

is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

In the case of any State which has had such a demonstration project reimbursement system in continuous operation since July 1, 1977, the Secretary shall provide under paragraph (3) for continuation of reimbursement to hospitals in the State under such system until the first day of the 37th month beginning after the date the Secretary determines and notifies the Governor of the State that either of the conditions described in subparagraph (A) or (B) of such paragraph has occurred. If, by the end of such 36-month period, the Secretary determines, based on the evidence submitted by the Governor of the State, that neither of the conditions described in subparagraph (A) or (B) of paragraph (3) continues to apply, the Secretary shall continue without interruption payment to hospitals in the State under the State's system. If, by the end of such 36-month period, the Secretary determines, based on such evidence that either of the conditions described in subparagraph (A) or (B) of such paragraph continues to apply, the Secretary shall (i) collect any net excess reimbursement to hospitals in the State during such 36-month period (basing such net excess reimbursement on the net difference, if any, in the rate of increase in costs per hospital inpatient admission under the State system compared to the rate of increase in such costs with respect to all hospitals in the United States over the 36-month period, as measured by including the cumulative

savings under the State system based on the difference in the rate of increase in costs per hospital inpatient admission under the State system as compared to the rate of increase in such costs with respect to all hospitals in the United States between January 1, 1981, and the date of the Secretary's initial notice), and (ii) provide a reasonable period, not to exceed 2 years, for transition from the State system to the national payment system.

(c) No payments to Federal providers of services

Subject to section 1395qq of this title, no payment may be made under this part (except under subsection (d) or subsection (h) of this section) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

(d) Payments for emergency hospital services

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(e) Payment for inpatient hospital services prior to notification of noneligibility

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(f) Payment for certain inpatient hospital services furnished outside United States

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(g) Payments to physicians for services rendered in teaching hospitals

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(h) Payment for specified hospital services provided in Department of Veterans Affairs hospitals; amount of payment

(1) Payments shall also be made to any hospital operated by the Department of Veterans Affairs for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1395x(w) of this title) with it, to an individual entitled to hospital benefits under section 426 of this title even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the

hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this subchapter.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Secretary of Veterans Affairs for such services, or (if less) the amount that would be payable for such services under subsection (b) of this section and section 1395ww of this title (as estimated by the Secretary). Any such payment shall be made to the entity which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

(i) Payment for hospice care

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(j) Elimination of lesser-of-cost-or-charges provision

(1) The lesser-of-cost-or-charges provisions (described in paragraph (2)) will not apply in the case of services provided by a class of provider of services if the Secretary determines and certifies to Congress that the failure of such provisions to apply to the services provided by that class of providers will not result in any increase in the amount of payments made for those services under this sub-chapter. Such

change will take effect with respect to services furnished, or cost reporting periods of providers, on or after such date as the Secretary shall provide in the certification. Such change for a class of provider shall be discontinued if the Secretary determines and notifies Congress that such change has resulted in an increase in the amount of payments made under this subchapter for services provided by that class provider.

(2) The lesser-of-cost-or-charges provisions referred to in paragraph (1) are as follow:

(A) Clause (B) of paragraph (1) and paragraph (2) of subsection (b) of this section.

(B) Section 1395m(a)(1)(B) of this title.

(C) So much of subparagraph (A) of section 1395l(a)(2) of this title as provides for payment other than of the reasonable cost of such services, as determined under section 1395x(v) of this title.

(D) Subclause (II) of clause (i) and clause (ii) of section 1395l(a)(2)(B) of this title.

(k) **Payments to home health agencies for durable medical equipment**

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(l) **Payment for inpatient rural primary care hospital services**

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42 U.S.C. §1395cc

Agreements with providers of services

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement --

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title),

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to

have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title, but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period of not less than one year if he finds such reduction is consistent with the objectives of this subchapter,

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person,

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of

this subchapter) with respect to the provider,

(E) to release data with respect to patients of such provider upon request to an organization having a contract with the Secretary under part B of subchapter XI of this chapter as may be necessary (i) to allow such organization to carry out its functions under such contract, or (ii) to allow such organization to carry out similar review functions under any contract the organization may have with a private or public agency paying for health care in the same area with respect to patients who authorize release of such date for such purposes,

(F)(i) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b), (c), or (d) of section 1395ww of this title, to maintain an agreement with a professional standards review organization (if there is such an organization in existence in the area in which the hospital is located) or with a utilization and quality control peer review organization in existence in the area in which the hospital is locate) or with a utilization and quality control peer review organization which has a contract with the Secretary under part B of subchapter XI

of this chapter for the area in which the hospital is located, under which the organization will perform functions under that part with respect to the review of the validity of diagnostic information provided by such hospital, the completeness, adequacy, and quality of care provided, the appropriateness of admissions and discharges, and the appropriateness of care provided for which additional payments are sought under section 1395ww(d)(5) of this title, with respect to inpatient hospital services for which payment may be made under part A of this subchapter (and for purposes of payment under this subchapter, the cost of such agreement to the hospital shall be considered a cost incurred by such hospital in providing inpatient services under part A of this subchapter, and (I) shall be paid directly by the Secretary to such organization on behalf of such hospital in accordance with a rate per review established by the Secretary, (II) shall be transferred from the Federal Hospital Insurance Trust Fund without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and (III) shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for

direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews),

(ii) in the case of hospitals, rural primary care hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of subchapter XI of this chapter for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (3)(a),

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1395ww of this title, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A of this subchapter but for a denial or reduction of payments under section 1395ww(f)(2) of this title,

(H) in the case of hospitals which provide services for which payment may be made under this subchapter and in the

case of rural primary care hospitals which provide rural primary care hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1395y(a)(14) of this title, and other than services described by section 1395x(s)(2)(K)(i) of this title, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (i) that are furnished to an individual who is a patient of the hospital, and (ii) for which the individual is entitled to have payment made under this subchapter, furnished by the hospital or otherwise under arrangements (as defined in section 1395x(w)(1) of this title) made by the hospital,

(I)

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(K) not to charge any individual or any other person for items or services for which payment under this subchapter is denied under section 1320c-3(a)(2) of this title by reason of a determination under section 1320c-3(a)(1)(B) of this title,

(L) in the case of hospitals, to provide inpatient hospital services for which payment may be made under this

subchapter, to be a participating provider of medical care under section 1703 of Title 38, in accordance with such admission practices, and such payment methodology and amounts, as are prescribed under joint regulations issued by the Secretary and by the Secretary of Veterans Affairs in implementation of such section,

(M) in the case of hospitals, to provide to each individual who is entitled to benefits under Part A of this subchapter (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains --

(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this subchapter,

(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

(iii) the individual's right to appeal denials of benefits for

continued inpatient hospital services, including the practical steps to initiate such an appeal, and

(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides such additional information as the Secretary may specify,

(N) in the case of hospitals and rural primary care hospitals --

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In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of subchapter XI of this chapter is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section items services (not in excess of the amount customarily charged for such items

and services by such provider), and (ii) an amount equal to 20 per centrum of the amount customarily charged for such items and services by such provider) for which payment is made under part B of this subchapter or which are durable medical equipment furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1395l(c) of this title, clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1395x(s)(10)(A) of this title, with respect to items and services furnished in connection with obtaining a second opinion required under section 1320c-13(c)(2) of this title (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B of this subchapter. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1395m(a) of this title, the amount of any deduction imposed under section 1395l(b) of this title and 20 percent of the payment basis

described in section 1395m(a)(1)(B) of this title.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2)

of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subpəragraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is gen one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(3) (A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(f)(i)) under the third sentence of section 1320c-3(a)(4)(A) of this title and under section 1320c-3(a)(14) of this title with respect to services, furnished by the hospital, rural primary care hospital, facility, or agency involved, for which payment may be made under this subchapter.

(B) For purposes of payment under this subchapter, the cost of such an agreement to the hospital, rural primary care hospital, facility, or agency shall be considered a cost incurred by such hospital, rural primary care hospital, facility, or agency in providing covered services under this subchapter and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, rural primary care hospital, facility, or agency in accordance with a schedule established by the Secretary.

(C) Such payments --

(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

(ii) shall not be less in the aggregate for a fiscal year --

(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

(II) in the case of facilities, rural primary care hospitals, and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities, rural primary care hospitals, or agencies under part B of subchapter XI of this chapter.

(b) Termination or nonrenewal of agreements

(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary --

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this subchapter and regulations thereunder, or with a corrective action required under section 1395ww(f)(2)(B) of this title,

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title, or

(C) has excluded the provider from participation in a program under this subchapter pursuant to section 1320a-7 or section 1320a-7a of this title.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall become effective on the same date and in the same manner as an exclusion from participation under the programs under this subchapter becomes effective under section 1320a-7(c) of this title.

(c) **Refiling after termination or nonrenewal; notice of termination or nonrenewal**

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(d) Decision to withhold payment for failure to review long-stay cases

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(e) "Provider of services" defined

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(f) Maintenance of written policies and procedures

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(g) Penalties for improper billing

Except as permitted under subsection (a)(2) of this section, any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment inconsistent with an arrangement under subsection (a)(1)(H) of this section or in violation of the requirement for such an arrangement, is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(h) Dissatisfaction with determination of Secretary; appeal by institutions or agencies; single notice and hearing

(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a

determination described in subsection (b)(2) of this section shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1320a-7 of this title and this section with respect to a determination or determinations based on the same underlying facts and issues.

(i) Intermediate sanctions for psychiatric hospitals

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42 U.S.C. §1395oo

Provider Reimbursement Review Board

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with

subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if-

(1) such provider-

(A) (i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 139h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply.

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(f) Finality of decision; judicial review; determinations of Board Authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination

is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination in writing within thirty day after the Bard receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5 notwithstanding any other provision in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such

provider as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

(g) Certain findings not reviewable

(1) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(2) The determinations and other decisions described in section 1395ww(d)(7) of this title shall not

be reviewed by the Board or by any court pursuant to an action brought under subsection (f) of this section or otherwise.

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42 U.S.C. §1395g

Payments to providers of services

(a) Determinatin of amount

The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of srvices shall be paid, at such time or times as the Secretary believes appropriate (but no less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amount so determined, with necessary adjustments on account of preiously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

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42 U.S.C. 1395h

Use of public or private agencies or organization to facilitate payment to providers of services

(a) Authorization for agreement by Secretary for implementation; scope of agreement

If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to the provisions of section 1395oo of this title and to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers (and to providers assigned to such agency or organization under subsection (e) of this section), and for the making of such payments by such agency or organization under subsection (e) of this section). Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to instiurions or agencies to enable them to establish and maintain fiscal records nexessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agenices, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication

from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform suh other functions as are necessary to carry out this subsection. As used in this subchaptr and part B of subchapter XI of this chapter, the term "fiscal intermediary" means an agency or organization with a contract under this section.

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42 U.S.C. § 1395x

Definitions

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations

(which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services an a per diem, per unit, per capita, or other basis, may provide for using different methods indifferent circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective, adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods

of determining costs proves to be either inadequate or excessive.

§405.704 Actions which are initial determinations.

(a) *Applications and entitlement of individuals.* An initial determination with respect to an individual includes the following --

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance;

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence requested by SSA to support the application. (SSA will specify in the initial determination the conditions of entitlement that the applicant failed to establish by not submitting the requested evidence);

(3) A denial of a request for withdrawal of an application for hospital or supplementary medical insurance;

(4) A denial of a request for cancellation of a "request for withdrawal"; and

(5) A determination as to whether an individual, previously determined to be entitled to hospital or supplementary medical insurance, is no longer entitled

to such benefits, including a determination based on nonpayment of premiums.

(b) *Requests for payment by or on behalf of individuals.* An initial determination with respect to an individual includes any determination made on the basis of a request for payment by or on behalf of the individual under part A of Medicare, including a determination with respect to:

(1) The coverage of items and services furnished;

(2) The amount of an applicable deductible;

(3) The application of the coinsurance feature;

(4) Require the exercise of medical judgment by the consultant physician.

(c) *Independent Laboratory Services Furnished to Hospital Inpatients.* Laboratory services furnished to a hospital inpatient by an independent laboratory (as defined in §488.52) will be reimbursed on a reasonable charge basis under this subpart only if they are physician laboratory services as described in paragraph (a) of this section. Payment for nonphysician services furnished to a hospital inpatient by an independent laboratory will be made by the intermediary to the hospital in accordance with part 413 of this chapter.

(a) The initial determination under §405.704(a) or (b) shall be final and binding upon the individual on whose behalf payment under part A has been requested or, if such individual is deceased, upon the representative of such individual's estate, unless it is reconsidered in accordance with §§405.710 through 405.717 or revised in accordance with §405.750. Such individual's estate if the individual is deceased) shall be the party to such initial determination.

(b) The initial determination under §405.704(c) shall be final and binding upon the provider of services unless it is reconsidered in accordance with §§405.704(c) shall be final and binding upon the provider of services unless it is reconsidered in accordance with §§405.710 through 405.717 or revised in accordance with §405.705. Such provider of services shall be the party to such initial determination.

42 CFR Ch. IV (10-1-91 Edition)

§405.710 Right to Reconsideration.

(a) An individual who is a party to an initial determination, as specified in §405.704(a) and (b), (or if such individual is deceased, the representative of such individual's estate) and who is dissatisfied with the initial determination may request a reconsideration of such determination in accordance with §405.711 regardless of the amount in controversy.

(b) A provider of services who is a party to an initial determination (as specified in §405.704(c)0 and

who is dissatisfied with such initial determination may request a reconsideration of such determination in accordance with §405.711, regardless of the amount in controversy, but only if the individual on whose behalf the request for payment was made has indicated in writing that he does not intend to request reconsideration of the intermediary's initial determination on such request for payment, or if the intermediary has a finding (see §405.704(c)0 that such individual did not know or could not reasonably have been expected to know that the expenses incurred for the items or services for which such request for payment was made were not reimbursable by reason of §411.15(g) or §411.15(k).
[55 FR 11021, Mar. 26, 1990]

42 CFR Ch. IV (10-1-91 Edition)

§405.711 Time and Place of Filing Request for Reconsideration.

The request for reconsideration shall be made in writing and filed at an office of the Social Security Administration or the Health Care Financing Administration or,in the case of a qualified railroad retirement beneficiary (see 20 CFR 404.368) filed at an office of the Railroad Retirement Board, within 60 days after the date of receipt of notice of initial determination, unless such time is extended as provided in §405.7123. A request for reconsideration which is filed with the intermediary which received the request for payment submitted on behalf of the individual is considered to have been filed with the Health Care

Financing Administration as of the date it is filed with the intermediary. For purposes of this section, the date of receipt of notice of the initial determination shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary. [41 FR 47917, Nov. 1, 1976. Redesignated at 42 FR 52826, Sept. 30, 1977]

42 CFR Ch. IV (10-1-91 Edition)

§405.724 Appeals Council Review.

Appeals Council review is provided by 20 CFR 404.967.

42 CFR Ch. IV (10-1-91 Edition)

§405.730 Court Review.

To the extent authorized by section 1869, section 1876(f), and section 1879(d) of the Act, a party to a decision of the Appeals Council (see 20 CFR 404.979) or the decision of a presiding officer where the request for review by the Appeals Council was denied, may obtain a court review where the amount in controversy after Appeals Council review is $1,000 or more, by filing a civil action in a district court of the United States in accordance with the provisions of section 205(g) of the Act (see 20 CFR 422.210 for the filing procedure). A party to a reconsidered determination may obtain a court review where the amount in controversy is $1,000

or more and he requests and meets the conditions for the expedited appeals process (see §405.718).

§405.750 Time Period for Reopening Initial, Revised, or Reconsidered Determinations and decisions or Revised Decisions of a Presiding Officer or the Appeals Council; Finality of Determinations and Decisions.

(a) *Reopenings Concerning Applications and Entitlement.* A determination, or decision, or revised determination or decision made by the Social Security Administration concerning any matter under §405.704(a), may be reopened and revised under 20 CFR 404.988 (Conditions for Reopening).

(b) *Reopenings Concerning a Request for Payment.* An initial, revised, or reconsidered determination of the Health Care Financing Administration, or a decision or revised decision of a presiding officer or of the Appeals Council, with respect to an individual's rights concerning a request for payment under Part A of Medicare, which is otherwise final under 20 CFR 404.955 or 404.981 and 405.708, or 405.717 of this subpart may be reopened:

(1) Within 12 months from the date of the notice of the initial or reconsidered determination to the party to such determination;

(2) After such 12 month period, but within 4 years after the date of the notice of the initial determination to the individual, upon establishment of good cause for reopening such determination or decision (see 20 CFR 404.9088(b) and 404.989); or

(3) At any time, when:

(i) Such initial, revised or reconsidered determination or such decision or revised decision is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting clerical error or error on the fact of the evidence on which such determination or decision was based; or

(ii) Such initial, revised, or reconsidered determination or decision or revised decision was procured by fraud or similar fault of the beneficiary or some other person.

§405.806 Effect of Initial Determination.

The initial determination shall be final and binding upon the party or parties to such determination unless sit is reviewed in accordance with §§405.810 through 405.812, or is revised in accordance with §405.841 by the carrier (or by the hearing officer presiding where a claim is not acted upon with reasonable promptness (see §405.801)).
[39 FR 12097, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept. 30, 1977]

§405.807 Review of Initial Determination.

(a) *General.* A party to an initial determination by a carrier, who is dissatisfied with such initial determination, may request that the carrier review such determination. If a review is requested, such action shall not constitute a waiver of the right to hearing (see §405.820) subsequent to such review.

(b) *Place of filing request.* A request for a carrier to review the initial determination is to be made in writing and filed at an office of the carrier or at an office of the Social Security Administration or the Health Care Financing Administration.

(c) *Time of Filing Request.* The carrier shall provide a period of 6 months after the date of the notice of its initial determination within which a party to the initial determination may request review. The carrier may, upon request by the party affected, extend the period for requesting the review.

[39 FR 12097, Apr. 3, 1974. Redesignated at 42 FR 52826, Sept, 30, 1977]

§405.1835 Right to Board Hearing.

(a) Criteria. *The provider (but no other individual, entity, or party) has a right to a hearing before the Board about any other matter designated in §405.1801(a)(1), if:*

(1) An intermediary determination has been made with respect to the provider; and

(2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and

(3) The amount in controversy (as determined in §405.1839(a)) is $10,000 or more.

(b) Prospective Payment Exceptions. Except with respect to matters for which administrative or judicial review is not permitted as specified in §405.1804, hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.

(c) *Right to Hearing based on Late Intermediary Determination about Reasonable Cost.* Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary's determination concerning the amount of reasonable cost reimbursement due a

provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report (as permitted or as required to furnish sufficient data for purposes of making such determination -- see §405.1803(a)) provided such delay was not occasioned by the fault of the provider.

APPENDIX E

Blue Cross

Medicare

Federal Medicare Intermediary
444 Forest Park
St. Louis, Missouri 63108-2292

August 6, 1985

Mr. Joseph Rallo
Board Advisor
Provider Reimbursement Review Board
Room 104, Professional Building
6660 Security Boulevard
Baltimore, MD 21207

RE: JR: 81-220 and 83-409
University of Missouri Medical Center, Columbia, Missouri
Provider No. 26-0141
PRRB Case No. 81-220, FYEs - June 30, 1979 and 1980
PRRB Case No. 83-409, FYE - June 30, 1981

Dear Mr. Rallo:

In accordance with your request in our recent telephone conversation, information is presented herein to assist

the Board in reaching a decision on their jurisdiction over the issue in dispute in the subject cases.

Pulmonary ICU Claims

During the audit and finalization of the subject cost reports, the Intermediary's auditors obtained listings of "processed" claims for Medicare beneficiaries who received Pulmonary ICU care as inpatients of the Veteran's Administration Hospital (VAH). Based on these listings the Intermediary's Audit and Reimbursement Department effected adjustments to cost reports to disallow the related Medicare days and charges and remove the related Part A deductibles and co-insurance.

While it had been the Intermediary's intent to reprocess and reject the claims for services rendered in the VAH as noncovered services rendered to inpatients of the VAH at the time these lists of noncovered Pulmonary ICU claims were transmitted to the Intermediary's Claims Department temporary systems problems prevented this action. Subsequently, because of the passage of time, HCFA priorities, and workload volume the Intermediary has determined that it would be administratively impracticable and cost prohibitive to reprocess and formally reject these claims. This corrects the statement in Section II, Item 10, Page 5 of the "Intermediary's Position on Jurisdiction" for PRRB Case No. 81-220. At this time, the Intermediary does not plan to reprocess and rescind the subject claims.

Enclosures from PRRB Case No. 76-190, PRRB Decision No. 79-D82

We enclose copies of the following information from our file on the previous case involving the subject Provider for the identical issue:

A. Letter from Intermediary to Ms. Erica L. Gosnell, Attorney Advisor.
December 11, 1979

B. Letter from HCFA, BPP, DISR to the Intermediary, August 19, 1980
(responding to inquiry of December 11, 1979).

C. Letter and enclosures from Provider to the Board, November 5, 1979,
including copies of:

1. P.L. 89-785
2. 38 U.S.C. 5051-5057
3. Legislative History -- P.L. 89-785
4. Legislative History -- P.L. 94-581
5. 38 U.S.C. 4117
6. 38 U.S.C. 5001

D. Federal Register, Vol. 42, No. 152, August 8, 1977, pages 39995-39997, "proposed amendments (to) incorporate the provisions of section 401 of the Indian Health Care Improvement Act (P.L. 94-437) and section 115(a) of the Veterans Omnibus Health Care Act (P.L. 94-581) into the (Medicare) regulations.

E. Federal Register Vol. 44, No. 9, January 12, 1979, pages 2592 and 2593, which canceled the proposed regulations at D. above, as they regarded P.L. 94-581 pertaining to services provided by VA hospitals.

By signing this letter, I certify that a copy of it (with enclosures) has been mailed to the Provider's representative, as specified below.

If there are any questions regarding this matter, please call Mr. Larry Driggers at 314-658-4391 or myself at 314-658-4308.

Very truly yours,

Cecil E. Terry
Audit Manager
Audit and
Reimbursement
Department
Government Programs
Division

CET:lag
Enclosures
cc: Mr. James S. Newberry, Counsel
bcc: Jim Beeler
John Vogel (M/R 695)
Larry Driggers
UMMC Appeal File
General File